MARYLAND AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Medical Record Number _____

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFR § 164.508 and the Annotated Code of Maryland, Title 10 Health General Article §§ 4-301 – 4-307.

All items on this authorization must be completed in full, or the request will not be honored.

I hereby authorize _____ (hereinafter referred to as the "entity") to release the protected health information of:

PATIENT: _____

DATE OF BIRTH: _____ PHONE #: _____

ADDRESS: _____

_____

The information is to be released to:

NAME: _____

ADDRESS: _____

PHONE #: _____

The information I wish to have released is (include dates of service):

_____

☐ Discharge summary
☐ History and physical exam
☐ Consultation reports
☐ Reports of operations
☐ Imaging reports
☐ Diagnostic cardiology reports
☐ Laboratory reports
☐ Other _____

☐ I do ☐ I do not wish to have information about HIV/AIDS released under this authorization.

☐ I do ☐ I do not wish to have mental health records released under this authorization.

☐ I do ☐ I do not wish to have information about drug/alcohol abuse treatment released under this authorization.

If **{covered entity name}** is in possession of records from another provider, ☐ I do ☐ I do not wish to have those records released under this authorization.

The purpose for such disclosure is:

☐ At my request (only patient may check)
☐ Healthcare
☐ Other _____
☐ Payment / Insurance
☐ Employment

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This authorization will expire one year from the date it is signed unless a shorter time is indicated here:

_____

I understand:

- This authorization is voluntary.
- My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form.
- I may receive a copy of this form.
- I may inspect my protected health information without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that action has been taken prior to receipt of revocation. To revoke the authorization, I understand that I must notify **{covered entity contact}** in writing.
- I understand that once information covered by this authorization has been disclosed redisclosure of the information by that recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by Maryland law.

_____ _____

Patient or Personal Representative's Signature Date

If signature is other than patient, explain your authority to act for the patient:

_____

_____

_____

_____ _____

Witness Date

If there is a question or concern with responding to this authorization, you will be contacted by the entity to discuss it. Questions or complaints about the federal privacy regulations or policies and procedures relating to these federal regulations should be directed to _____.